Annual Review 1986

Office of the Chief Medical Examiner

Alberta
ATTORNEY GENERAL

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Introduction

The Office of the Chief Medical Examiner of the Province of Alberta is responsible by statute* for the investigation and certification of all deaths by violence, as well as unexpected, unexplained, or unattended deaths. Certain hospital and institutional cases, notably those of persons dying within ten days of surgery or anesthesia, are included. Deaths of persons held involuntarily are also investigated. The area of jurisdiction is the Province of Alberta, with a population of approximately 2.3 million. In addition to the resident population, the Medical Examiner has jurisdiction over those who travel through the province each year.

The Medical Examiner system, under the direction of the Chief Medical Examiner, is managed from two regional offices, one located in Calgary and the other in Edmonton. Both of the regional offices are under the direction of a Deputy Chief Medical Examiner. The Edmonton office administers the northern part of the province, and the Calgary office administers the geographical area south of a horizontal line between Jasper and Provost, through Hobbema. Each office has a permanent staff of four medical investigators, six forensic autopsy technicians and three record technicians. Additional staff members include supervisors, administrators, photographers/radiographers, a research officer and assistant, and secretaries. The Chief Medical Examiner is based in Calgary.

A medical investigator and medical examiner are on duty evenings and weekends for investigations and consultations. Autopsies and examinations are performed daily. A toxicology laboratory is included in both facilities; they are directed by Ph.D. Biochemists who have technologists on staff.

Approximately 150 medical examiners and 25 pathologists are on a part-time, fee-for-service basis throughout the province. In the two central offices, approximately 50 per cent of the medical examiner cases were investigated and certified by the full-time medical examiner's staff. The remainder of the cases were examined and certified by part-time medical examiners who are assisted by pathologists, city police and RCMP in other parts of the province. Their continuing support and willingness to perform this valuable community service has made it possible to maintain a high quality provincial Medical Examiner system.

The Office of the Chief Medical Examiner in Alberta first started the medical investigator programme in Canada, and was the first such system anywhere to recruit persons with exclusively medical training to fill the role as investigators. The idea has now received support in the United States. The Office of the Chief Medical Examiner in Alberta was the first medico-legal jurisdiction in Canada to be inspected and accredited by the National Association of Medical Examiners, an American based organization whose standards for accreditation of Medical Examiner/Coroner systems and facilities are unique.

The Office of the Chief Medical Examiner in Alberta began a tissue donation programme in 1984. Next-of-kin were contacted very shortly after the death and asked to consent to donating the corneae of the deceased. This year, 37 pairs of eyes were made available, representing a positive response from 73 per cent of those families approached.

In 1986, a total of 4,675 deaths were reported to the medical examiner. This accounts for approximately one out of three deaths in Alberta during that period. The report developed by the medical examiner in each case contains information on the cause, manner and circumstances surrounding the death.

* The Fatality Inquiries Act and the Vital Statistics Act.

Caseload Statistics

Total Cases

Certified Cases

Manner of Death	Total Cases	Aggregate Rate per 100,000 population
Natural	2,040	85.4
Homicide	68	2.8
Suicide	431	18.0
Accidental	903	37.8
Unclassified	172	7.2
Undetermined	86	3.6
Other Cases*	975	—
TOTAL	4,675	195.6

*Other Cases: cases which are reported but do not require a full investigation. (See Refereed Cases.)

Regional Distribution of Cases

	Calgary	South Rural	Edmonton	North Rural	Total
Natural	488	415	767	370	2,040
Homicide	16	13	22	17	68
Suicide	84	89	137	121	431
Accidental	138	223	181	361	903
Unclassified	19	31	86	36	172
Undetermined	21	24	24	17	86
TOTAL	766	795	1,217	922	3,700

Caseload Review 1975 – 1986

	Calgary	South Rural	Edmonton	North Rural	Total
1975	664	656	689	741	2,750
1976	669	572	602	764	2,607
1977	678	800	658	827	2,963
1978	783	796	902	911	3,392
1979	920	876	1,084	975	3,855
1980	1,011	957	1,142	983	4,093
1981	944	934	1,223	917	4,018
1982	973	838	1,325	884	4,020
1983	965	826	1,295	849	3,935
1984	748	875	1,286	908	3,817
1985	633	874	1,244	849	3,600
1986	766	795	1,217	922	3,700

Refereed Case Review *

	1981	1982	1983	1984	1985	1986
Calgary	323	295	304	463	601	465
South Rural	70	45	104	158	91	104
Edmonton	124	98	225	201	303	312
North Rural	41	45	58	61	81	94
TOTAL	558	483	691	883	1,076	975

* "Refereed" cases are deaths reported to the medical examiner according to Section 15 of the Vital Statistics Act, and deferred to the attending physician on the basis that the death was natural, that he is able to certify the medical cause of death with reasonable accuracy and that he has received the consent of the medical examiner.

Types of Death Investigated and Certified

Homicides

	Male	Female	Total
Calgary	13	3	16
South Rural	5	8	13
Edmonton	16	6	22
North Rural	9	8	17
TOTAL	43	25	68

Alberta rate per 100,000 population	2.8
Canadian rate per 100,000 population	1.7

Method

Fight/brawl	5
Hanging/strangulation	8
Firearms	18
Stabbing/incised wound	28
Poison	3
Other/unspecified	6
TOTAL	68

Suicides

Age Group	Male	Female	Total	Rate/100,000
10 – 14	4	4	8	4.8
15 – 19	36	9	45	24.2
20 – 24	44	10	54	22.3
25 – 29	47	7	54	20.7
30 – 34	50	16	66	28.5
35 – 39	32	9	41	21.6
40 – 44	24	6	30	21.4
45 – 49	22	3	25	22.2
50 – 54	20	7	27	26.1
55 – 59	20	5	25	26.3
60 – 64	14	4	18	22.0
65 – 69	8	3	11	16.9
Over 70	23	4	27	21.1
TOTAL	344	87	431	18.0

Month of Death

	Calgary	South Rural	Edmonton	North Rural	Total
January	2	10	15	10	37
February	3	8	9	6	26
March	12	7	10	10	39
April	5	8	13	13	39
May	12	8	10	8	38
June	8	5	16	14	43
July	2	5	9	10	26
August	9	8	10	13	40
September	9	6	10	9	34
October	5	3	9	8	25
November	8	14	13	7	42
December	9	7	13	13	42
TOTAL	84	89	137	121	431

Suicides 1975 – 1986

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
Calgary	78	84	88	90	83	103	94	109	106	82	105	84
South Rural	69	60	76	79	56	91	70	63	70	83	88	89
Edmonton	68	97	89	84	104	99	97	112	120	135	102	137
North Rural	72	78	97	81	82	107	103	97	124	123	100	121

Suicide Rates Per 100,000 Population

Year	Estimated Population (000's)	Total Suicides	Rate/ 100,000
1960	1,291.1	115	8.9
1961	1,332.0	120	9.0
1962	1,369.0	120	8.8
1963	1,402.0	118	8.4
1964	1,430.0	162	11.3
1965	1,450.0	162	11.2
1966	1,463.2	145	9.9
1967	1,490.0	135	9.1
1968	1,524.0	160	10.5
1969	1,559.0	195	12.5
1970	1,595.0	204	12.8
1971	1,627.9	191	11.7
1972	1,675.3	212	12.6
1973	1,689.5	222	13.1
1974	1,722.4	281	16.3
1975	1,811.8	287	15.8
1976	1,885.2	319	16.9
1977	1,965.8	350	17.9
1978	2,028.8	334	16.5
1979	2,109.6	325	15.4
1980	2,205.1	400	18.1
1981	2,293.5	364	15.9
1982	2,347.7	381	16.2
1983	2,361.0	420	17.8
1984	2,300.0	423	18.1
1985	2,348.8	395	16.9
1986	2,389.5	431	18.0

Method

	Male	Female	Total	Percentage
Drug overdose/poison	39	35	74	17
Carbon monoxide	68	17	85	20
Hanging/strangulation	68	12	80	19
Submersion	4	1	5	1
Firearms	144	15	159	37
Incised wounds	3	3	6	1
Jumping	12	2	14	3
Other	6	2	8	2
TOTAL	344	87	431	100

National Suicide Rates* Per 100,000 Population 1975 – 1986

	1975	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986
National Rate	12.4	12.8	14.3	14.8	14.1	14.0	14.0	13.9	15.1	13.7	12.9	14.5
Newfoundland	3.5	3.8	3.7	2.6	4.4	3.4	4.2	6.0	6.2	6.7	4.0	4.0
Prince Edward Island	11.9	19.5	10.0	13.1	13.1	11.4	7.4	8.9	12.9	12.0	3.9	11.1
Nova Scotia	10.4	10.4	11.3	12.5	12.6	11.5	10.9	12.2	12.1	9.9	12.0	10.8
New Brunswick	8.0	10.9	10.5	12.9	12.1	11.6	11.1	12.9	14.2	12.6	12.0	13.5
Quebec	9.3	10.5	12.4	14.2	15.4	14.8	16.4	16.5	18.5	15.7	17.1	17.6
Ontario	13.5	13.0	14.5	14.3	13.0	13.1	12.5	12.7	12.9	12.3	11.4	12.4
Manitoba	13.1	14.1	17.5	15.4	14.7	11.8	14.0	13.4	15.8	12.7	11.9	14.4
Saskatchewan	14.9	14.0	15.6	17.3	14.9	15.9	17.7	17.5	14.9	13.5	13.0	13.7
Alberta	15.8	16.9	17.9	16.5	15.4	18.1	15.9	16.2	16.7	17.2	16.9	17.9
British Columbia	16.9	16.4	17.6	18.3	16.2	14.8	14.5	15.0	14.8	13.4	10.4	14.7
Yukon**	1.9	1.8	2.4	3.2	2.7	5.0	2.2	2.9	3.6	2.3	3.5	4.3
Northwest Territories**	1.7	1.6	2.8	5.5	1.8	2.0	2.2	1.7	4.3	3.4	2.5	2.9

*Source: Statistics Canada **Rates based on 10,000 population.

Accidental Deaths

Motor Vehicle Accidents

	Calgary	South Rural	Edmonton	North Rural	Total
Driver	25	71	30	129	255
Passenger	24	44	27	75	170
Unknown occupant	0	0	2	0	2
Subtotal	49	115	59	204	427
Pedestrians Struck by Motor Vehicle	20	5	15	16	56
Motorcycle Accidents	11	8	10	4	33
Train Collisions					
Driver of motor vehicle	1	1	0	1	3
Passenger in motor vehicle	0	0	0	0	0
Pedestrian	0	3	0	3	6
Passenger on train	0	0	0	16	16
Subtotal	1	4	0	20	25
Bicycle Accidents	2	2	2	2	8
Motor Vehicle Collapsed on Victim	1	1	0	1	3
TOTAL MOTOR VEHICLE ACCIDENTS	84	135	86	247	552

Industrial Accidents

Asphyxia	3
Drowning	3
Electrocution	5
Exsanguination	2
Explosion	5
Fall	7
Struck by equipment	4
Train collision	6
Struck by tree	6
TOTAL INDUSTRIAL ACCIDENTS	41

Farm Accidents

Equipment roll over	3
Crushed by machinery	8
Clothing entangled in power take-off	2
Air crash while crop spraying	1
Fall from hay bales	1
Explosion of tire wheel	1
Child charged by cow	1
Dragged while roping horse	1
Drowned; fell from horse while herding cattle	1
TOTAL FARM ACCIDENTS	19

Other Accidents

Air crash	18
All-terrain vehicle	2
Asphyxia/aspiration	16
Avalanche	4
Burns	3
Carbon monoxide	16
Crushed by object	4
Dirtbike	3
Dragged on tire tube	1
Drowning	39
Drug overdose	11
Electrocution	2
Exsanguination	1
Fall	83
Fall from horse	6
Firearm	2
Fire	40
Four-wheeled vehicle	1
Gas leak; explosion	1
Hydrogen sulphide gas	1
Hyperthermia	1
Hypothermia	9
Late effects of trauma	6
Lightning	1
Parachute	1
Roller coaster	3
Snowmobile	6
Therapeutic misadventure	8
Ultralight	2
TOTAL OTHER ACCIDENTS	291

TOTAL ACCIDENTAL DEATHS **903**

Unclassified Deaths *

	Calgary	South Rural	Edmonton	North Rural	Total
Chronic and/or acute alcoholism and sequelae	9	16	51	20	96
Drug overdose	5	4	14	5	28
Alcohol and drug overdose	2	2	12	5	21
Hypothermia due to intoxication	0	2	1	2	5
Methyl alcohol	1	4	8	1	14
Fall related to intoxication	1	0	0	0	1
Aspiration of food due to intoxication	1	3	0	1	5
Drowning due to intoxication	0	0	0	2	2
TOTAL	19	31	86	36	172

* Evidence of alcoholism or drug misuse is a direct part of the primary medical cause of death.

Undetermined Deaths *

	Calgary	South Rural	Edmonton	North Rural	Total
Unable to determine exact cause of death	4	10	10	6	30
Drug overdose	7	3	2	3	15
Other or unspecified	1	1	5	1	8
Carbon monoxide	3	1	2	2	8
Drowning	2	0	2	1	5
Jump from height	0	0	1	0	1
Burns, fire	0	1	0	0	1
Unspecified substances	2	1	0	0	3
Asphyxia	0	2	1	0	3
Motor vehicle accident	0	5	1	2	8
Other gas	0	0	0	1	1
Hypothermia	0	0	0	1	1
Alcohol intoxication	1	0	0	0	1
Train-pedestrian	1	0	0	0	1
TOTAL	21	24	24	17	86

* Undetermined whether accidental, self-inflicted, or homicide.

Sudden Infant Death Syndrome

Age Group	Calgary	South Rural	Edmonton	North Rural	Total
Less than 1 month	2	1	0	3	6
1 – 3 months	10	15	18	12	55
4 – 6 months	5	5	8	7	25
7 months and older	2	0	2	1	5
TOTAL	19	21	28	23	91

Sudden Infant Death Syndrome is the leading cause of death among infants from one week to one year of age. In Alberta, S.I.D.S. accounted for 91 infant deaths in 1986. The overall incidence of S.I.D.S. has been reported as 1.8 cases per 1,000 live births. Although it can occur at any time during the first year of life, the peak incidence in Alberta is during the first three months.

S.I.D.S. Statistics for Selected Cities

	1980	1981	1982	1983	1984	1985	1986
Calgary	14	22	24	15	12	11	19
Edmonton	17	25	26	26	22	27	28
Lethbridge	3	2	4	0	1	1	5
Fort McMurray	0	0	1	0	3	1	2
Red Deer	4	1	1	1	0	1	2
St. Albert	0	0	1	0	1	0	0
Medicine Hat	2	2	1	2	2	1	1
Leduc	0	0	1	0	1	0	1
Grande Prairie	0	0	1	0	2	0	3
Camrose	0	0	1	0	0	0	1

Public Inquiries

Public Inquiries Summary

Manner of Death	Judicial Recommendations for the Prevention of Similar Deaths: Given	Not Given		
Natural	3	4		
Homicidal	2	0		
Suicidal	7	4		
Accidental	11	10		
Unclassified	0	0		
Undetermined	1	2		
TOTAL	24	20	=	44

Types of Public Inquiries

Hospital/Institutional Related

Natural	2
Suicide	5
Undetermined	2
Accidental	
Aspiration	2
Fall	1
Self-poisoning	1
Misadventure	2
TOTAL	15

Motor Vehicle Related

Collisions	2
Struck by bus	1

Occupational Related

Hit by tree	1
Hit by train	1

Police/Incarceration Related

Suicide	4
Natural	2
Homicide	2
Undetermined	1
Accidental	
Fall	1
Drug overdose	3
Drug and alcohol overdose	1
Crushed by machinery	1
TOTAL	15

Other

Suicide	2
Natural	3
Accidental	
Fall	1
Air crash	2
Drowning	1
TOTAL	9
TOTAL PUBLIC INQUIRIES	**44**

Case History 1

Suicide. Deceased was a patient under warrant for examination at Alberta Hospital Ponoka.

Recommendations:

1. That if a procedure is not already in place, that a procedure be adopted by Alberta Hospital Ponoka and other facilities treating patients on a non-voluntary basis, that will ensure that medication prescribed is ingested by the patient at the time it is prescribed.
2. That the laboratory department of the facility undertaking a toxicological examination be provided with a list of medications prescribed for the subject and that the laboratory conduct specific tests to confirm the presence of such medications as might reasonably be expected to be present under all of the circumstances.

Replies:

ALBERTA HEALTH

1. Recommendation 1 is in place but it is difficult to be sure if every patient who is prescribed medication, and who is observed to be taking it, actually swallows it. This is fully recognized as a problem in all psychiatric in-patient units.
2. The second recommendation is also relevant, but does not necessarily lead to any different result since it is not possible to test for every substance which a patient might ingest. These recommendations have been brought to the attention of the appropriate medical staff committees to incorporate, if necessary, into policy and procedures.

ALBERTA HOSPITALS AND MEDICAL CARE

Alberta Hospital Ponoka has taken appropriate action. There is presently a system in place to ensure that patients are ingesting their medications. Moreover, they have formulated a plan of action to ensure that appropriate tests are conducted.

ALBERTA ATTORNEY GENERAL

1. It is not possible for any toxicology laboratory to detect **all** types of drugs by "general screening" procedures. Some drugs are of such low dosage and/or are so extensively broken down in the body that they may be difficult to detect even when searched for specifically. Such is the case with the antipsychotic medication prescribed in this instance.
2. Medical examiners and pathologists already have instructions requesting that a list of medications prescribed be provided to the toxicology laboratory at the time specimens are submitted for analysis.
3. Where there is obvious concern about a matter relating to toxicological analysis it would be better if those concerns were discussed with a knowledgeable forensic toxicologist at an early stage.

ALBERTA HOSPITAL PONOKA

1. Currently the procedure is already in place for the medication nurse to ensure that patients report for their medication at the prescribed medication times, and for the nurse to stay with the patient to check that the medication is ingested properly.
2. The list of medications prescribed for the patient is routinely provided to the medical examiner to forward to the laboratory department of the facility undertaking a toxicological examination. Follow-up confirmation of specific tests conducted will be requested.

Case History 2

Suicide. The deceased took a drug overdose when he was given temporary control of his own medication prior to being moved from one place of residence to another.

Recommendations:

1. Persons in charge of Interval House should have clear written instructions with regard to control of drugs required by the residents of that location.
2. Patients in transit from Interval House to another place of residence should not be given control of their own drugs if they have not previously had such control.
3. Ambulance personnel should better communications with the emergency wards of hospitals to ensure that proper first aid is administered to patients in transit at the earliest possible time.
4. Ambulance personnel should have direct communications with the emergency ward doctor to make sure that he or she has all of the information regarding the patient in question.
5. Persons who have overdosed on Cogentin or Orap, or any drug when the full effect of the drug overdose is not known, should be monitored in an active treatment hospital for a minimum of 24 hours.

6. A case history summary of this case should be reviewed by all doctors practicing emergency care medicine.

Replies:

ALBERTA SOCIAL SERVICES AND COMMUNITY HEALTH

1. In the contractual arrangement with Interval House, it is clearly stated that supervision of a resident's medication is required as part of an individual service plan. Interval House has an operational manual which outlines various procedures for the care of residents including control of medication. Medications are maintained in a locked cupboard and are not dispensed by staff because this is the responsibility of a doctor or a nurse. There is no nurse on staff at Interval House.
2. It is standard practice at Interval House, as it is in other facilities, that the person transporting the resident maintains control of the medication and delivers it to the staff of the residence accepting the patient. Again, this is outlined in the operational manual of Interval House.

ALBERTA MEDICAL ASSOCIATION

The report was placed on the agenda for the Committee on Mental Health.

ALBERTA HOSPITAL ASSOCIATION

Although the association is not in a position to take direct action on the recommendations, we will circulate the case history summary to all active treatment hospitals to heighten awareness and assist in developing policy in managing such cases.

ALBERTA HOSPITALS AND MEDICAL CARE

A case history summary was incorporated into an Information Bulletin and distributed to hospitals.

EDMONTON GENERAL HOSPITAL

In regard to recommendations 3 and 4, these have been discussed with the proper ambulance authorities and it is now the policy of the emergency department to obtain as much information as possible regarding the patient.

In regard to recommendation 5, the clinical head of the emergency department states that it is now part of the departmental policies.

In regard to recommendation 6, after considerable discussion with the Alberta Hospital Association, it has been agreed that the AHA will circulate this to all Alberta hospitals for general information.

ALBERTA HOSPITAL EDMONTON

Point #5 of the recommendations is complied with by the hospital.

INTERVAL HOUSE

Present procedures at Interval House are as follows:

1. The resident's doctor must orally approve release of medications to the resident discharged to an independent living arrangement.
2. If the resident is transferred to another facility, his or her medications are transferred to the person in charge of the new facility.

ALBERTA AMBULANCE OPERATORS ASSOCIATION

The association agrees that there should be better communication between the ambulance attendants and the receiving hospital. However, until such time as there is legislation in place governing ambulance communications, there is no guarantee that this type of problem will be rectified.

ALBERTA MUNICIPAL AFFAIRS

No comments to make.

Case History 3

Suicide. Deceased was an inmate of the Edmonton Institution who was being treated in the Health Care Centre. He died the day prior to being transferred to the federal penitentiary at Prince Albert.

Recommendations:

1. That the rooms (or cells) in which inmates are held in the Health Care Unit of the Edmonton Institution be equipped with closed circuit electronic surveillance cameras preferably with audio monitoring capability.
2. That there be better coordination of drug therapy prescribed for a given inmate.
3. That drug therapy as a means of treating the emotional, psychological and psychiatric problems of inmates be used only as a last resort and that drug dosages be kept to an absolute minimum.

Replies:

EDMONTON INSTITUTION

1. Electronic surveillance equipment has been installed in two in-patient rooms of the Health Care Centre. This provides for primary observation (constant) and a secondary monitoring system as well.
2. At the time of this fatality, Health Care Policy provided all medications and treatments to be reviewed every 30 days by the prescribing practitioner. Since this incident, medication reviews are accomplished on a regular

monthly schedule and attended by the physician, psychiatrist, pharmacist, dietitian and all duty nursing staff.

Chemotherapy is only one of the protocols utilized in treating inmate/patients with emotional, psychological and psychiatric problems. Counselling by professional staff, institutional staff, psychologist, etc. is employed, and treatment modalities such as biofeedback and relaxation therapy are utilized. Because the number of clients with histories of substance abuse is known to be high, drug therapy is applied only when indicated and under specific prescription of the psychiatrist or medical practitioner.

CORRECTIONAL SERVICE CANADA

1. Two cells in the Health Care Centre were equipped with video cameras. These cameras can be monitored from two separate areas within the institution.
2. The Edmonton Institution now has a Medication Review Committee. This committee meets monthly to review all inmate medications for the previous month.
3. Medications are only ordered by qualified physicians or psychiatrists. Normal prescribing procedures are followed.

Case History 4

Homicide. This man was depressed over a recent separation from his wife and had been drinking. He had in his possession several weapons and the police were notified. When he would not put down his weapon as ordered, a police dog was twice sent in to take him. The dog did not attack. When the deceased brought his rifle up to point at a constable, he was shot by the officer.

Recommendations:

1. An **independent** inquiry be conducted and a review be undertaken of police policy and procedures in Code 300 operations.
2. The supervision and staffing of Code 300 operations be reviewed and positive direction be provided concerning the minimum confirmed rank that the senior Command Post Officer must hold.
3. The establishment of clear and comprehensive guidelines aimed at reducing the number of direct confrontations between police officers and subjects in Code 300 situations, thereby reducing the need for "judgement calls" by police officers in those situations.
4. The establishment of clear and comprehensive guidelines for the deployment of police negotiators in Code 300 operations.
5. A review of the role that the tactical unit should be required to assume in Code 300 operations, including:
   a) An examination of the existing requirement that the tactical unit can only be called in if a criminal offence has been committed.
   b) An examination of the existing requirement that only the senior officer at a command post in Code 300 operations can call in the tactical unit. Some procedures should be put in place whereby other senior police officers might be authorized to intervene and override the decisions of the senior officer at the command post in certain situations.
   c) The establishment of clear and comprehensive guidelines for the deployment of the tactical unit in Code 300 operations.
   d) The feasibility of assigning members of the tactical unit to monitor Code 300 operations at all times and relay tactical unit suggestions to the senior officer at the command post through a Code 300 dispatcher.
6. Formalization of the requirement that two dog handlers with their police service dogs be deployed at an early stage in Code 300 situations.
7. An examination of current policy relating to the training of police service dogs. This training has evolved to a point where their aggression level is being more controlled and more emphasis is placed on control and holding than on attack and biting.

   Would it be feasible, for example, to have one or two dogs held in reserve who are trained only to attack and bite, and who could be deployed in certain Code 300 situations where their use was considered warranted?

Replies:

LAW ENFORCEMENT APPEAL BOARD

The Board will not be conducting a review of police policy and procedures in Code 300 operations. The board only has jurisdiction on those matters given to it by the Police Act.

ALBERTA SOLICITOR GENERAL

The law provides that police commissions have sole responsibility for the policy direction of police departments.

CALGARY POLICE SERVICE

The service has acted upon the recommendations.

1. Whenever possible, permanently promoted sergeants will be in charge at Code 300s.
2. Clear and comprehensive guidelines designed to reduce the number of direct confrontations are already in place.
3. Clear and comprehensive guidelines for use of police negotiators are already established.
4. a) This is an inaccurate assumption. Tactical units respond when requested, whether or not a criminal offence has been committed.

   b) The senior officer at the command post is the appropriate individual to call in the tactical unit since he is the member with the most information. The authority for the intervention of, or overriding by, another senior officer is already established in the procedure and in the chain of command.

   c) Duties of the tactical team are clearly established. However, instructions as to when they should be called to Code 300 will be clarified.

   d) This suggestion is not feasible. The size of the tactical unit would have to be doubled, which could not be justified economically or practically.
5. This is the practice now, subject to availability. It will be formalized in policy, remaining subject to availability.
6. Current policy is believed to be appropriate, i.e., emphasizing control and holding over attacking and biting. It would not be feasible to hold dogs and handlers in reserve trained only to attack and bite. There could never be a guarantee that any dog would react as expected in **all** situations, and it could be years between incidents where they would be used.

CALGARY POLICE COMMISSION

This commission has reviewed the police responses to the recommendations and is satisfied that with the implementation of the changes in Code 300 procedure, the service has taken the necessary steps to adjust Code 300 procedure to comply with the recommendations.

Case History 5

Natural. This young boy was a severe asthmatic with numerous allergies. He became wheezy following a ride on a horse while at summer camp. He died before reaching hospital.

Recommendations:

1. A registered nurse should be on full-time duty at camps of this size and distance from hospital facilities.
2. Senior personnel at camp should have first aid and CPR training.

Replies:

ALBERTA CAMPING ASSOCIATION

1. The Alberta Camping Association is currently reviewing and rewriting its standards and, in light of the recommendations made, these standards will likely be made stronger. For example, many of the member camps already have a First Aid/CPR requirement for all staff; however, we would emphasize necessity by including a standard which reflects our concern for the overall safety of campers.
2. Camps, regardless of size, are encouraged to have an R.N. on site. It is very difficult, however, to get an R.N. on staff as many of these positions are very low paying due to the volunteer/non-profit status of most camps.

   An article in the next issue of our quarterly newsletter will urge all ACA camps to evaluate their current emergency procedures as well as encourage them to have the highest qualified medical person on-site as is feasible for them.

CIRCLE SQUARE RANCH

1. Every effort will be made to have a registered nurse as part of staff and services for the months that summer camp is conducted, this being the months of July and August.
2. Senior staff members will obtain a certificate in both artificial respiration and CPR to equip them to deal with emergency situations.

ALBERTA RECREATION AND PARKS

Discussion will take place with the Alberta Camping Association on their standards program.

Case History 6

Accidental. The deceased ingested some pills while in police custody for being intoxicated in a public place. The deceased exhibited no symptoms that would cause police to believe that he required medical attention. During a routine check the deceased was found unresponsive in his cell.

Recommendations:

That when lodging intoxicated persons in cells and there is evidence that drugs may have been ingested, police officers ought to obtain medical advice concerning that person's condition, preferably from that person's physician.

Replies:

ALBERTA SOLICITOR GENERAL

The recommendation has been communicated to the Chiefs of Police and the Commanding Officer of the RCMP in Alberta with a request that procedures be reviewed in compliance with the recommendation.

ROYAL CANADIAN MOUNTED POLICE

The recommendation has been given careful consideration and a review of our policy indicated that such a problem has been previously addressed and operational policy for field personnel issued.

Hopefully, this policy will provide sufficient guidance to field personnel to help prevent any further incidents of this nature.

Case History 7

Natural. The decedent had a history of asthma. She was found dead at her residence hours after having surgery on her nose. She had been an outpatient at a clinic.

Recommendations:

1. That asthmatic or epileptic patients be hospitalized for procedures such as rhinoplasty or other minor operations for the purpose of monitoring their vital signs postoperatively when a lot of medication is being administered.
2. Consultation should also take place between the practitioner carrying out these procedures and the medical doctor attending the patient for asthmatic or like conditions.

Replies:

DR. H.V. DONALDSON, ANAESTHESIOLOGIST

The second part of the recommendation is standard protocol in outpatient surgery.

However, the first part of the recommendation is disagreed with for three reasons:

Firstly, the clinical validity of the recommendation is to be questioned. Epileptics are at risk for an increase in seizure incidence whenever subjected to stress of any kind, e.g., surgery. The drugs used in anaesthesia for epileptics are almost all excellent anti-epileptics. Epileptics recovering from an anaesthetic in which barbiturates have been used are at a **lesser** risk of seizures. Asthmatics who have been ventilated and/or hyperventilated with oxygen and halothane have an **improved** pulmonary function for up to 48 hours.

Secondly, increasing the restrictions on those eligible for outpatient surgery runs counter to the current trend of liberalizing said restrictions. Paul F. White, Ph.D., M.D., Assoc. Prof. of Anaesthesia at Stanford, and Director of Outpatient Surgery for Stanford University Hospital, is an acknowledged expert in outpatient surgery. He feels that outpatient surgery can be performed on patients with pre-existing medical problems that are under good control, including ASA status 111. (1) (2).

Thirdly, recommendations which are promulgated to cover every eventuality and leave no room for expert discretion are to be deplored. These are the types of well intentioned remarks that grow into rules, mushroom into regulations and may even become laws.

ALBERTA MEDICAL ASSOCIATION

The Committee on Anaesthetic and Operative Deaths of the Alberta Medical Association has reviewed this death. No evidence has been presented to suggest that this death would have been prevented by hospital admission for elective surgery.

If patients with medical problems similar to the deceased are in optimal condition prior to the proposed elective surgical procedure, then there is no medical indication that hospital admission is necessary.

COLLEGE OF PHYSICIANS AND SURGEONS

The information will be made available to the profession.

Case History 8

Suicide. Following a domestic dispute, the deceased took his own life. He had a long history of being violent.

Recommendations:

Where members of a family, as a matter of pride or ignorance, will not indicate to the police or the courts that an offending member of the family may have mental problems, it is difficult for the police or the courts to act. However, it might be wise for a court, when faced with an accused who has on more than one occasion offered serious violence to members of his family, to order a mental or psychiatric examination and thus perhaps subject the accused to treatment so as to prevent further violence or tragedy.

Replies:

MINISTER OF JUSTICE OF CANADA

Preventive measures already exist within the overall structure of a firearms control program enacted through the *Criminal Law Amendment Act, 1977 (1976-77, C.53, S.3).*

ALBERTA ATTORNEY GENERAL

The inquiry report has been referred to the Chief Judge of Alberta for his consideration.

Case History 9

Accidental. The deceased was killed as he was departing from a school bus. He was struck by a vehicle which was passing the school bus in the right hand parking lane.

Recommendations:

1. That a special class of license be created for school bus drivers, the obtaining of which be a pre-condition to the operation of that sort of vehicle.
2. That the successful completion of the School Bus Driver Improvement Program be a pre-condition to obtaining that license.
3. That provision be made for a periodic review and updating of training for all those holding this class of license.
4. That all schools be required to develop and present to student passengers a short formalized program aimed at creating awareness in all those who travel on school buses, as well as familiarizing them with safety procedures to be followed in the event of an accident or emergency.
5. That the various provisions be physically consolidated into a small booklet to be distributed to every new applicant for a license of whatever class and to presently licensed drivers upon the renewal of their licenses.
6. That the written examination required of applicants for driver's licenses be expanded to include more questions specifically related to the duties of drivers with respect to school buses.
7. The recommendation procedure in the latest edition of the School Bus Driver Improvement Program is: "Pull as far to the right as possible before stopping the bus and choose a location that allows students a safe footing." This should be given the force of the law so that all school buses in the province adopt the same practice.
8. School bus stops which require children to cross busy traffic areas should be minimized. Signs warning approaching motorists of school children **crossing the highway**, not just of school bus stops, should be mandatory at stated intervals before every such stop.
9. That infractions involving school buses be removed from the Specified Penalty Listing and personal court appearances be required.
10. That all school buses in rural areas which pick up and discharge students on roads outside of municipal boundaries be required to carry, in addition to the driver, a second adult to supervise loading, unloading and discipline during transportation.

Replies:

ALBERTA SOLICITOR GENERAL

1. Changes to the Alberta Driver's Handbook relative to school bus operation have been made. A list identifying all school bus owners was also provided to the association so that they could send out additional literature to school bus operators and areas of concern relating to the School Bus Driver Endorsement Code Program.
2. Since many of these recommendations involve both the departments of the Solicitor General and Transportation, the Motor Vehicles Division will work with the Transportation Safety Branch in terms of addressing these recommendations, as well as others, to ensure that standards/regulations meet the demands of the Alberta public.
3. A very high emphasis has been placed on driver management and, as a result, the Motor Vehicles Division has recently reorganized to set up a new section to focus totally on this subject. As part of this section's mandate,

all elements of driver control and safety will be reviewed. School bus operations will be high on the priority list.

ALBERTA EDUCATION

The recommendation to encourage all schools to develop and present to students a program aimed at creating a greater awareness of student passenger responsibilities and safety considerations is well taken. Such a program is offered in many schools at the present time and personnel of Alberta Transportation, Alberta Education and Alberta Advanced Education, together with representatives of the Student Transportation Supervisors' Association and the Federation of Alberta Home and School Associations, are working on a film to increase awareness of the student's responsibility while a passenger on a school bus.

Alberta Education personnel responsible for conducting transportation reviews routinely encourage and advise school boards to revise routes in order to eliminate pick-up and drop-off points which require children to cross highways, and where possible, to reduce to an absolute minimum on-highway pick-up and drop-off points.

With regard to the last recommendation, many school boards have for some time required a second adult to travel with students on buses operating outside the school jurisdiction's boundaries, that is, on field trips and sports trips. While implementation of such a policy would be a matter for each school board to consider, nevertheless Alberta Education certainly supports the intent of the recommendation in its present form with respect to field trips and similar excursions.

ALBERTA TRANSPORTATION

1. A school bus driver improvement program is now in place and is being implemented by all but two school divisions that use school buses. At the moment, participation in this program is voluntary but the Minister has stated that it will be made mandatory if participation drops. A few school jurisdictions have made successful completion of this training a condition of employment.
2. Transportation Safety Branch presently offers a School Bus Rider Safety presentation which is delivered through the Regional Safety Educational Representatives.
3. The Motor Vehicle Division's Handbook covers the responsibilities of drivers who encounter school buses. This is done pictorially and through text. The examination for an operator's licence includes appropriate questions.
4. The recommendation to regulate the positioning of a bus when it is stopped to load or unload will be brought forward during regular amendment reviews of the Highway Traffic Act.
5. The "school bus stop ahead" sign used in Alberta displays a school bus with children exiting to the left and right. This sign is standard and is used in most provinces and states. The signs are used where the stop is concealed, not obvious or in an unexpected location.
6. Penalties for infractions of Section 105 of the Highway Traffic Act have been reviewed. Alberta Transportation will continue to encourage police forces to maintain a reasonable and consistent level of enforcement. School bus drivers are also being encouraged to report violators.
7. The decision as to whether or not to employ a second adult supervisor on some or all school buses in a fleet must be taken by the school division.
8. The report will be referred to the Minister's Advisory Committee for Traffic Safety.

Case History 10

Natural. Following his arrest for impaired driving, the deceased was taken to the drunk tank in Gleichen. He became uncooperative and attempted to prevent the closure of the cell door. The officer had to use some force to release the deceased's grip on the cell bars. The deceased took a few steps back, lost his balance, fell back, and hit his head on the cement floor with considerable force.

Recommendations:

1. That a padded cell is needed or a cell constructed with different materials than cement.
2. Possibly closer continuous supervision.

Replies:

ALBERTA SOLICITOR GENERAL

A more appropriate flooring material for "drunk tanks" will be used in any future modification to existing facilities or the construction of new facilities.

The new material being used in this regard is called Plad 270 which is basically a tough, non-porous elastomeric flooring. The thickness of this material can be varied for anticipated movement, comfort and impact and its application appears to be suitable for the accommodation of public inebriates.

ROYAL CANADIAN MOUNTED POLICE

Our Property Management Branch in Ottawa is currently investigating the suitability of Plad 270 for use in our police cells.

Case History 11

Accidental. The deceased was the pilot of an aircraft which struck the Royal Alexandra Hospital while attempting to land at the Edmonton Municipal Airport.

Recommendations:

1. The wearing of shoulder harnesses by flight crews should be mandatory for all aircraft during take-off, approach and landing, and in any emergency situations.
2. Aircraft used for passenger carriage should be equipped with a flight data and cockpit voice recorder, which would likely indicate the cause of any accident and would save time and expense in any investigation.
3. The ELT antenna specifications should be revised to try and ensure protection for the antenna system in any crash.
4. The fuel management system should be reviewed in this type of aircraft.

Replies:

CANADIAN AVIATION SAFETY BOARD

The board has no authority to implement regulatory changes.

TRANSPORT CANADA

The recommendations will be reviewed by officials and you will be advised of action to be taken.

FEDERAL MINISTER OF TRANSPORT

1. Present regulations require that every person in an aircraft have their safety harness fastened while the aircraft is taking off and landing and at any other time when directed by a member of the crew. The latter includes approach and emergency situations.

   As to the installation of shoulder harnesses, Transport Canada officials agree that protection of the persons occupying flight crew seats by the addition of shoulder harnesses in small commercial aircraft is desirable. In compliance with the recommendations of the Commission of Inquiry on Aviation Safety, work is in progress to incorporate elements of the Federal Aviation Administration (FAA) operational rules into Canadian regulations.

   For small (nine seats or less) aeroplanes (FAR 23), this would impose retroactive installation of shoulder harnesses in front seats of commercial aeroplanes manufactured after 1978, as stated in FAR 91.33 (a) (13).

   The FAA has not yet addressed retroactivity for shoulder harness installations in small aeroplanes manufactured prior to 1978. Transport Canada will conduct a study on the feasibility of introducing such legislation.

   Transport Canada will also increase the aviation community's awareness of the benefits of installing and using shoulder harnesses in privately-owned aircraft.

   Aviation Safety Promotion will focus on the fact that studies reveal instances where shoulder harnesses, although installed, are not being worn during flight. These findings indicate an attitudinal problem and foreshadow other questions which may also be addressed by our Regional Aviation Safety Officers (RASOS).
2. Transport Canada officials are working with the aviation industry, other governments, and agencies to develop appropriate regulations to be issued in 1988, for fixed wing aircraft, and in 1989, for rotary wing.
3. Transport Canada is in full accord with this recommendation. Current ELTs are built to specifications which were drafted almost twenty years ago. New specifications are currently being developed which explicitly address this recommendation.
4. Transport Canada officials reviewed the fuel system of this aircraft and report that the fuel switches were in the proper position for flight at impact. They also reviewed the certification of this fuel system and found that the accident aircraft was in compliance with the regulation.

Case History 12

Accidental. As the result of an air crash.

Recommendations:

1. The commissioner, under the Fatality Inquiries Act, should be granted the full powers of the commissioner appointed under the Public Inquiries Act without reservation, as though he were in fact a federally appointed judge.
2. The appeal committee provided for under the statute should have represented thereon, a member of the Provincial Court of Alberta, the pool from which the commissioners are appointed under the Fatality Inquiries Act.

3. It should be spelled out in the Fatality Inquiries Act that once a hearing has been embarked upon, that if the commissioner should come to the conclusion that it is in conflict with any other public inquiry that has been heard or is presently in progress, that the inquiry could or should be adjourned sine die pending further review of any inquiry which has been held or which is in of the province on his own initiative or the commissioner already appointed under the Fatality Inquiries Act could reopen the said inquiry if there are questions which are left unanswered by such concurrent or previous inquiry.

4. It has been my experience that various law enforcement agencies in the past sought to use the Fatality Inquiries Act as an additional tool in an investigation to ascertain whether charges could be proven or should be proceeded with. This is not the purpose for which the inquiry has been convened and it should rarely, if ever, be allowed to be utilized in this fashion.

5. Better cooperation with the Chief Medical Examiner's Office must be required by statute. This cooperation must be specifically spelled out whether it is for the provincial or federal governments and/or an agency of either one.

6. At present, counsel for the inquiry or counsel to the commissioner under the Fatality Inquiries Act is in fact counsel for the Attorney General of the Province of Alberta. It is now, and always has been, my firm belief that this counsel should be specifically appointed as commission counsel responsible to the commissioner.

7. That the statute (Canadian Aviation Safety Board Act) should be thoroughly reviewed and it is recommended that it be specifically spelled out in the said statute that "all the facilities and resources of the ministry of transport are to be made available to the investigators and/or the inquiry."

8. The requirement that the Canadian Aviation Safety Board make an interim report to the Minister should not exist as such, but a full report should be made as speedily as possible to the Minister who should then be required to take it to cabinet forthwith.

9. The statute requires that the Canadian Aviation Safety Board make the report available to any federal department directly or indirectly affected by their findings prior to it being presented to cabinet, and that the affected department has 90 days in which to respond to such criticism and/or observations. This creates an undue delay. It is my view that such departments should be given notice that they are or may be affected by the evidence and that they might then appear by counsel before the Board as should any other interested party. This is a shortcoming in the present statute and should be remedied forthwith.

Replies:

TRANSPORT CANADA

Departmental staff have conducted a thorough review of the report.

In acting on recommendations involving amendments to legislation or operating procedures, it is the policy of Transport Canada to thoroughly review and analyze the circumstances in which those recommendations were developed, as well as the circumstances of the accident which led to those recommendations. In this way, Transport Canada is assured of responding quickly and effectively to valid safety concerns and can correct any transportation deficiencies to improve the overall safety of the system.

In reviewing the report of the inquiry, we found a number of errors which were serious enough to lead us to question the validity of the recommendations. These errors of fact pertained to the organization of the Canadian Aviation Safety Board (CASB), the interpretation of the CASB Act, the relationship of the Board of Transport Canada and the authority conferred on Transport Canada regional staff.

Based on review, at this time, Transport Canada will take no action as a result of these recommendations. However, further information, revision of the report or development of new recommendations will also be considered.

CANADIAN AVIATION SAFETY BOARD

The Canadian Aviation Safety Board is continuing discussions with the National Association of Chief Coroners and Chief Medical Examiners in order to develop agreements that can be concluded between our Board and the governments of the various provinces. These agreements are intended to ensure that procedures and practices are as compatible as possible with those followed by police or coroners in the provinces, the whole in accordance with Section 14 of the Canadian Aviation Safety Board Act.

ALBERTA ATTORNEY GENERAL

Although the recommendations do not relate to the prevention of similar deaths, very careful note has been taken with respect to the comments made.

Case History 13

Accidental. A north bound vehicle left the road, crossed the median and struck a south bound vehicle.

Recommendations:

A median barrier sufficient to withstand vehicle penetration would have limited this accident to one vehicle.

Replies:

ALBERTA TRANSPORTATION AND UTILITIES

The provision of a median barrier for Highway #2 was given every serious consideration as a treatment to cross-median collisions but was deemed unsuitable.

A program is currently underway to both widen the depressed median and the median shoulder. This additional width is expected to compensate substantially for driver errors or manoeuvres leading the vehicles to enter the median. The entire widening program cannot be accomplished immediately but the current program has one project scheduled each year. One project is complete and another nearly complete. This should see the entire narrow median section revised by the mid 1990s.

Case History 14

Suicide. The deceased, who was a patient in the psychiatric ward of the Lethbridge Regional Hospital, appeared anxious, confused and fearful, but he was left alone for a few minutes. He jumped from the window of an unoccupied room.

Recommendations:

1. Where possible, psychiatric patients should be restricted to first level (street) and no higher than second storey levels.
2. Windows should be unbreakable and well secured in their frames.
3. When psychiatric patients undergo mood changes there should be a higher degree of supervision as well as consultation with the attending psychiatrist.

Replies:

LETHBRIDGE GENERAL HOSPITAL

1. We are not able to do anything about the current psychiatric facility; however, the new psychiatric facility, which will be open in 1988, will be on the ground level.
2. The windows have always been unbreakable. We now believe that they are well secured in their frames.
3. Our present policy reads as follows:

   The responsible physicians, at admission to the ward and during stay on the ward, will determine the level of patient observation required. This will be determined by the clinical state of the patient with particular reference to the risk of self harm or harm to others.

   Besides careful observation for all patients there will be two special levels.

   Close — All new patients will be placed on close observation for the first 24 hours unless a specific order from the responsible physicians states otherwise.

   The following apply to patients on close observation:

   - to be checked by nursing staff at least every 15 minutes
   - nurse to know whereabouts at all times
   - not to attend Day Treatment Centre unless accompanied by nurse from ward
   - may go off the ward only accompanied by a nurse

   Constant — With a doctor's order for constant observation there will be constant (continuous) observation of the patient 24 hours a day. This will automatically apply to any patient where restraint is ordered.

ALBERTA HOSPITALS AND MEDICAL CARE

The Lethbridge Regional Hospital has already taken steps in an attempt to prevent similar deaths.

COLLEGE OF PHYSICIANS AND SURGEONS

The information will be made available to the profession.

Case History 15

Undetermined. The deceased died following routine surgery.

Recommendations:

1. More intensive house staff follow-up during the first 24 hours after surgery, with particular emphasis on the effects of analgesics and anti-nauseants on oxygen delivery to the tissues.
2. Reassess nurse staffing needs for the first 24 hours after surgery.
3. Review and reassess the current standard of information-gathering by nurses in the first 24 hours after surgery.
4. Review and reassess the criteria for nurses calling the house staff within the first 24 hours after surgery.

Replies:

STURGEON GENERAL HOSPITAL

1. Sturgeon General Hospital does not have "house staff." However, on occasion, interns and residents accompany active staff physicians for a period of time. The attending physician in each case is a trained, duly qualified and experienced specialist, and is aware of the effects of analgesics and anti-nauseants on oxygen delivery to the tissues.
2. Staffing levels are determined by Alberta Hospitals and Medical Care based on patient census. This matter will be reviewed with input from that department.
3. The standard established at Sturgeon General Hospital was met. Standards and practices in place at other hospitals were researched and it was found that standards in this hospital are comparable.
4. The criteria as set out were followed by nurses who are trained, duly qualified and ex enced. There was no deviation from the standard

ALBERTA HOSPITALS AND MEDICAL CARE

The response from the ad hoc committee of the Sturgeon General Hospital is appropriate. The staffing level of nursing at this facility is higher than that at most community-based active treatment hospitals.

ALBERTA ASSOCIATION OF REGISTERED NURSES

Legal proceedings have been commenced concerning this death and, therefore, it would be inappropriate to address this matter at this time.

ALBERTA HOSPITAL ASSOCIATION

No reply to date.

Case History 16

Accidental. An elderly patient in a nursing home accidentally ingested oil of wintergreen, believing that he was taking castor oil.

Recommendations:

1. All medication, prescription and non-prescription, should be in the custody of nursing home staff.
2. No resident should be allowed to keep medication, prescription or non-prescription, in their room.
3. There should be a regular review of all medication being administered to or taken by all nursing home residents by the personal physician and/or nursing home staff at least every 30 days. All such medication should be recorded for each resident on one document relating to that resident.
4. Nursing home staff should have access to the residents' rooms and private quarters, and in particular to locked areas where medication or other substances might be concealed. Residents should be made aware of this policy, and reminded of it periodically.
5. When any known or suspected toxic substance is ingested by a resident, the Poison Control Centre should be contacted immediately, without the need for medical authorization.
6. The Federal Health Protection Branch should be urged to require all manufacturers of toxic substances — and in particular oil of wintergreen — to package their product in a distinctive container with prominent notification of the dangers of internal consumption. Such containers should be recognizable to touch as well as vision, to enable individuals with impaired vision or non-fluency in either of our official languages to be aware of the nature of the substance in their possession.
7. Any such revised toxic container policy should be the subject of an intensive public awareness program, so that all Canadians acquire that knowledge.
8. Steps should be taken to restrict the sale of toxic substances — and in particular oil of wintergreen — to pharmacies only, and to be sold only after approval by a licensed pharmacist.

Replies:

HEALTH AND WELFARE CANADA

1. While consideration has been given to requiring a distinctively shaped bottle for the dispensing of poisonous substances such as oil of wintergreen, it was concluded that it would discourage consumers from reading the labels and be against the Health Protection Branch's administrative policy to encourage consumers to always read them. On the other hand, currently promulgated regulations will require that by the target date of August 1, 1987, methyl salicylate, among other common causes of poisoning, will be required to be dispensed in a child resistant package. The labelling will also require a caution that the drug should be kept out of the reach of children and that it is not for internal use. It is felt that these measures will substantially reduce the danger of accidental poisoning with oil of wintergreen and similarly toxic salicylates.

2. The implementation of the policy requiring a child resistant package for products containing more than 5% methyl or other alkyl salicylates was announced in an Information Letter and distributed to all pharmacists, drug manufacturers and public advocacy groups. Consideration will be given to additional publicity at the time of final implementation.

3. The regulations require that oil of wintergreen be sold only in pharmacies in Alberta.

ALBERTA PHARMACEUTICAL ASSOCIATION

1. The Institutional Practise Committee of the Association has developed the following recommendations for pharmacists practising pharmacy in the Province of Alberta:

   i) Pharmacists have a responsibility for the control of drug use in the nursing homes which they service and thus they should:

      a) Provide in-service education for nursing home staff to make the staff aware of the possibility that drugs or related substances may be brought into the nursing home by relatives, friends, etc., and that such drugs or substances may be subject to misuse;

      b) Ensure that a policy is in place in the nursing home that requires a physician's order for any drug which is to be self-administered;

   ii) Pharmacists should provide education on a regular basis to staff and residents of the nursing homes regarding the poisoning potential of common household substances (may include plants);

   iii) Pharmacists should ensure that the PADIS (Poison and Drug Information Service) address and phone number is readily visible at each nursing station;

   iv) Nursing home staff should be encouraged to use pharmacists as resource persons for consultation on drug-related issues;

   v) Pharmacists should ensure that nursing home staff are aware of on-call procedures;

   vi) Pharmacists should be reminded of the current regulations pertaining to methyl salicylate (oil of wintergreen) regarding labelling;

   vii) Methyl salicylate (oil of wintergreen) as a single ingredient, or in preparations and strengths of more than 30 per cent, should be removed from the self-selection area of Alberta pharmacies and be stored for sale to the public only in the prescription department.

   These recommendations and those of the judge were published in the official publication of the Alberta Pharmaceutical Association.

2. The following resolution was considered and ultimately approved at the Annual Meeting of the Canadian Pharmaceutical Association.

   Resolution:

   Whereas deaths have resulted from the accidental ingestion of methyl salicylate (oil of wintergreen) in both children and adults, and

   Whereas there is no therapeutic need for the use of methyl salicylate as a single entity agent, and

   Whereas the use of methyl salicylate as a rubefacient (analgesic rub) could be in combination with other agents,

   Therefore, be it resolved that the Alberta Pharmaceutical Association request the Health Protection Branch to remove methyl salicylate as a single entity product from the Canadian market.

ALBERTA LONG TERM CARE ASSOCIATION

Implications will be reviewed from a number of perspectives — the uppermost being the well-being of residents in long term care facilities.

ALBERTA HOSPITALS AND MEDICAL CARE

It has been confirmed that the administration of the nursing home in question has given this matter their attention and the follow-up has been initiated and carried out.

BUREAU OF DRUG QUALITY

No reply to date.

CAREWEST

Carewest has reinforced some previous practices and established new procedures in an attempt to prevent the recurrence of a similar incident.

1. All residents and, where possible, their families, are advised at the time of admission that all medications must be ordered by the attending physician and administered by a registered nurse. This practice has been carried out in the past and is being reinforced. Where a physician orders that a medication, such as nitroglycerine, be left at the resident's bedside for emergency purposes, the registered nurse is responsible for checking on a regular basis to ensure that the resident is taking the medication correctly.

2. The procedure for checking residents' drawers and closets is being carried out more frequently, on a more formalized basis, and greater emphasis is placed on checking for medications.

3. Medications are reviewed and rewritten by the physician every 90 days and the health record and medications are reviewed by the pharmacist every three months on a routine basis. The Medication Profile/Medication Administration Record Sheet is reviewed every 30 days by the pharmacist and revised as necessary. All medications are given and signed for by the registered nurse on the Medication Administration sheet. These procedures were in place and are being maintained.

4. A new policy has been developed for the use of locked drawers by the residents. A locked drawer has been provided for each resident, keyed to a master key for access by the nursing supervisors should there be any reason to suspect that harmful substances are being stored. A letter is being sent to each resident or a family member, as appropriate, advising of this policy. The policy will be discussed with new admissions.

5. The Poison Control Policy for emergencies has been reviewed and revised to provide that where a suspected toxic substance has been ingested by a resident, the Poison Control Centre will be contacted immediately for advice as to appropriate action and the physician then be contacted for authorization. In addition, each nursing unit has been supplied with the drug reference book "Drugs and Nursing Implications," Govonii & Hayes.

Case History 17

Accidental. While clearing snow from a carpark at Grande Cache Provincial Correctional Centre, the deceased was crushed by a boom at the back of the machine.

Recommendations:

Greater care should be taken in correctional institutions to ensure equipment used by prisoners is in prime condition and that proper safety and training seminars are made available to prisoners before they are allowed to use potentially dangerous equipment.

ALBERTA SOLICITOR GENERAL

Divisional policies and procedures were strengthened to ensure that:

a) all inmate operators of motorized equipment are certified as qualified to operate such equipment after having passed a test at the respective correctional centre;

b) the equipment is inspected prior to being operated by an inmate;

c) both the competency of the inmate operator and the inspection of the motorized vehicle or equipment are certified in writing and placed on the file.

ALBERTA COMMUNITY AND OCCUPATIONAL HEALTH

The investigation carried out by the Occupational Health and Safety Division and the resulting discussions with correctional staff would indicate that the corrective action has been implemented.

Case History 18

Homicide. The deceased was an inmate of the Edmonton Institution when he received multiple stab wounds.

Recommendations:

1. Establishment of detailed video surveillance at any location in the Edmonton Institution where inmates are permitted to gather.

2. Electronic detection equipment at all doorways leading from cellblock areas into recreational or work areas for detection of hidden weapons in possession of inmates.

Replies:

EDMONTON INSTITUTION

1. In our opinion, detailed video equipment will not achieve the desired objective. We have a number of cameras within the institution, but the major emphasis is on dynamic security where staff are expected to make contact with inmates. This, I feel, is an essential component of maintaining personal contact throughout their shift.

2. Electronic detectors work only for the detection of metal objects. Inmates do make weapons out of plexiglass and/or wood. Consequently, electronic detection equipment would not be effective. Again, as mentioned in my response to the first recommendation, staff contact is far more appropriate.

CORRECTIONAL SERVICE CANADA

1. The introduction of detailed video equipment for all locations that permit inmates to gather would not achieve the desired results or be practical within the institution. Video equipment is utilized in specific areas of the institution where it is deemed appropriate. Institutional staff carry out both dynamic and static security functions. Contact by the staff with the inmate population is essential, to maintain good programs.

2. Electronic detection equipment is valuable when inmates pass through and you wish to detect metal objects. However, inmates also carry objects that are made of wood and plastic that would go undetected. The introduction of this equipment would not achieve the desired effect. The placement of this equipment in all areas of inmate movement would lead to inmate frustration with a probable result of increased confrontations with staff and other inmates.

Case History 19

Accidental. Three children drowned when the raft in which they were floating was caught in the weir on the Oldman River.

Recommendations:

1. That the City of Lethbridge undertake to continue to study ways and means of advising its citizens and users of the river of the danger of the weir and general safety procedures to be followed.

Replies:

CITY OF LETHBRIDGE

1. The City has installed warning and directional signs on both the east and west banks of the Oldman River both above and below the weir.
2. The City has constructed a portage around the weir utilizing the present water intake canal with steps erected to make exit and entry from and to the river more accessible.
3. Signs have been erected prohibiting the crossing of the weir.
4. An emergency boat launch facility will be erected in the very near future.
5. Instruction on safe use of the river has been included in city sponsored swimming instruction and fire prevention programs in the schools.
6. The media have been acquainted with new facilities adjacent to the weir which resulted in considerable coverage and a video presentation of the facilities is now on file with the media for future presentation.

ALBERTA ENVIRONMENT

We concur with the findings and recommendations of the judge's report.

Case History 20

Suicide. The deceased was an inmate of the Fort Saskatchewan Correctional Institution. He had expressed concern about his upcoming release from prison and he committed suicide the day prior to his anticipated release.

Recommendations:

As the release from prison for many inmates who have spent in excess of four months is, in itself, a very stressful occurrence, it is recommended that all such prisoners who have a record of a previous suicide attempt be given a psychological assessment in the two weeks immediately preceding their release, and, if necessary, counselling and treatment.

Replies:

ALBERTA SOLICITOR GENERAL

The recommendation will be implemented immediately within the Alberta Correctional Service.

Case History 21

Suicide. The deceased was a patient of Alberta Hospital Edmonton. He had recently been transferred from Ontario where he had been admitted for a drug overdose and major depression. He was on reduced medication, was compliant and courteous with staff, and was showing apparent improvement. He had been granted a pass and spent the weekend with his parents. He met his demise following his return to the hospital.

Recommendations:

On provincial transfers of mental patients it is my view that a primary responsibility rests on the forwarding hospital to courier a copy of the patient's complete medical file, together with an updated status report from his attending physician, so that these items arrive at the receiving hospital before or with the patient. Alternatively, there should be telephone communication between the two attending physicians simultaneously with the transfer.

Replies:

ALBERTA HOSPITALS AND MEDICAL CARE

Alberta Hospital Edmonton has been contacted regarding their intent with respect to the recommendation. The Executive Director has indicated that Alberta Hospital is in full agreement with the recommendations. He further indicated that the matter has been referred to the Clinical Director who will discuss the recommendations with the Medical Advisory Committee. The department will be provided with a status report when discussions have concluded.

QUEENSWAY CARLETON HOSPITAL

It is surprising that information relating to the transfer was not apparently introduced at the inquiry. Actions to provide pertinent information on the transfer of the deceased to the Alberta Hospital Edmonton and to its staff were as follows:

1. A psychiatrist in the hospital spoke to the medical director of Alberta Hospital Edmonton, at which time he discussed facts relevant to the patient and obtained approval for interprovincial transfer.
2. A psychiatric nurse from the hospital travelled with the patient to Edmonton. On arrival, the nurse delivered the final discharge summary relating to the deceased's hospitalization, and in addition, orally provided current information on the patient's condition.
3. In addition to the most recent discharge summary, the psychiatric nurse delivered discharge summaries from previous admissions to the hospital and reports of psychological testing performed here during these earlier admissions.

The Queensway Carleton Hospital customarily provides all pertinent medical records to receiving health care institutions and individual physicians when transferring a patient and strongly supports this practice.

ALBERTA HOSPITAL ASSOCIATION

The recommendations and circumstances of the death are such that the AHA could not be of much assistance in this instance.

ALBERTA HOSPITAL EDMONTON

While the hospital can appreciate the recommendation that the complete medical file be forwarded to the receiving hospital, there is considerable question as to whether it is necessary to have the complete clinical file forwarded or just an up-to-date summary that covers the case and, in particular, difficulties associated with the case. The hospital has very recently developed a policy for interprovincial transfers and the requirement to have an appropriate clinical summary accompany the patient will be included in the policy. Also, there was considerable information forwarded to Alberta Hospital about this patient.

There is always a communication by telephone with the Alberta Hospital medical director, who in turn writes a report which is placed on the patient's file. This was done in the case of the deceased. In all cases, the medical director requests information from the referring facility about the patient's clinical condition to ensure that we are in a position to accept the patient. This form of communication will be continued in the future. Also, the medical staff are being informed that if they are not satisfied in any way with the written material forwarded on the patient, or information received over the telephone, then that physician should telephone the attending physician at the facility to obtain any additional information.

HEALTH AND WELFARE CANADA

The issue of interprovincial transfers is usually covered in provincial mental health acts and as such is exclusively within provincial jurisdiction.

ALBERTA MEDICAL ASSOCIATION

The recommendations were considered by the Committee on Mental Health at its regular meeting of April 15th, 1987. We agreed that the recommendation sounded most appropriate, but only on the assumption that there was no transfer of information.

Case History 22

Accidental. While being treated for meningitis, the deceased was accidentally administered a 50 per cent solution of paraldehyde instead of a 5 per cent solution.

Recommendations:

That a follow-up check be made with Glaxo Canada Ltd. that they are labelling the paraldehyde container as having a 100 per cent concentration.

Replies:

GLAXO CANADA LTD.

Glaxo Canada Ltd. is in compliance with the recommendations, having added the potency on the carton label and the ampoule. A special meeting was held on May 7, 1986 to initiate the label change. The remaining label and ampoule stock was quarantined and destroyed. The revised labels were used for the next lot of sterile paraldehyde that was manufactured.

ALBERTA MEDICAL ASSOCIATION

The Committee on Pharmacotherapy will look at the report.

CANADIAN PHARMACEUTICAL ASSOCIATION

This matter has been presented to the Professional Practice Committee for follow-up.

Case History 23

Accidental. The deceased was crushed by a falling tree.

Recommendations:

1. While tree falling operations are in progress, only one employee should be occupied in the actual operation of tree cutting within a particular block with define boundaries of a pre-designated "grid" or "checkerboard" area, comprised of a number of such blocks.
2. The provisions of the Occupational Health and Safety Act and Regulations thereunder should be strictly complied with, particularly as to the distance to be maintained between workers and the on-site supervision of the worksite by a qualified supervisor while tree cutting is in progress.
3. It is further recommended that on-site education be given to workers engaged in tree cutting operations, particularly those who are youthful and inexperienced. This training should emphasize the parameters of the particular job requirements and the individual employee's need for constant self-awareness and self-monitoring of his own conduct and the environment around him.

Replies:

ALBERTA COMMUNITY AND OCCUPATIONAL HEATH

1. All three recommendations are in keeping with the requirements of the General Safety Regulation under the Occupational Health and Safety Act and thus are the policy of this Division. Officers will continue to require compliance with these recommendations.

Case History 24

Accidental. Following a motor vehicle accident, the deceased was transported by air ambulance from Peace River to Edmonton. He died while en route.

Recommendations:

1. Periodically scheduled checks by a qualified medical officer, preferably a medical doctor, should be made of the medical equipment on board all aircraft ordinarily used or intended to be used as air ambulances. These checks should ensure, firstly, the sufficiency of such equipment for medical emergencies reasonably expected to be encountered on medical evacuation flights and, secondly, to verify that all items of such equipment are operating satisfactory and have received the necessary maintenance to reasonably ensure their proper functioning when needed.
2. A check list of required medical equipment should be prepared prior to each specific medical evacuation flight by the designated medical person in charge of the flight. The airplane interior should be inspected prior to departure by the designated medical person to ensure the presence of all items of equipment contained within the check list.

Replies:

ALBERTA HOSPITAL ASSOCIATION

The Association will be circulating the recommendations to its member hospitals with comment from legal counsel.

SECTION OF EMERGENCY MEDICINE, ALBERTA MEDICAL ASSOCIATION

1. At the present time, there are no standards set up for the type of aircraft, or equipment on these aircrafts, to be called an air ambulance. The Section of Emergency Medicine and the Alberta Medical Association Transport Committee are actively involved with trying to convince the Provincial Government to establish a unified ground and air ambulance system, such that cases such as this will never recur.
2. The second area of major concern is the level of staffing on the air ambulance on transport. In future it should be mandatory that licensed physicians or extremely well trained flight teams, consisting of nurses or paramedics who have ATLS and ACLS skills, be positioned on air ambulances so that active treatment can be given en route to the tertiary care centres.

PEACE RIVER HOSPITAL COMPLEX

The Chief of our Medical Staff has been assigned to make a twice yearly inspection of all medical equipment on board designated aircraft. Part of this inspection shall be to ascertain the functional aspects of this equipment. The referring physician shall be responsible for ascertaining that all necessary medical equipment and supplies are on the aircraft.

ALBERTA HOSPITALS AND MEDICAL CARE

The current Emergency Air Ambulance Service policy in the province provides authority to any practising physician, licensed by the College of Physicians and Surgeons in Alberta, or in his/her absence, a registered nurse or Emergency Medical Technician (EMP-P), to order an air ambulance from a listing of approved carriers based throughout the province. There are no equipment standards listed in the policy. It is the responsibility of the physician requesting the service to determine the type and level of medical escort(s) and equipment required for the patient during trip. Specialized teams are used to coordinate and provide the

service in communities such as Grande Prairie and Fort McMurray. This is advantageous because of the establishment of protocols as well as the availability of expertise. Equipment is maintained and checked regularly by the personnel who complete the majority of trips.

The department has requested that the Peace River Hospital ensure that adequate policies and procedures are in place to ensure that medical equipment is properly maintained and inspected regularly.

ALBERTA AMBULANCE OPERATORS ASSOCIATION

The Association will be addressing the issue of air transport in its current review of patient transfers.

COLLEGE OF PHYSICIANS AND SURGEONS

The information will be made available to the profession.

For more information or additional copies of this report, contact:

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